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Missouri Division of Medical Services

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Dental Bulletin

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ATTENTION DENTISTS!

This bulletin contains important information about changes to the adult dental program.

DENTAL SERVICES FOR CHILDREN

Dental services for children under 21 years old (except ME code 76) remain covered and are not subject to the changes in this bulletin regarding adult dental services.

MC+ MANAGED CARE PROGRAM

MC+ managed care health plans provide dental benefits to their enrollees. The dental benefits for adults under MC+ managed care is the same as fee-for-service.

Authorization and billing requirements outlined in this bulletin apply to services provided to MC+ and Medicaid recipients who receive their services on a fee-for-service basis.

Check with the MC+ managed care health plans for their authorization and billing requirements.

ADULT DENTAL SERVICES

The following changes in dental program coverage are effective for dates of service on or after July 1, 2002.

COVERED SERVICES

Dental services for adults are limited to dentures and trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. The following benefits, limits, and restrictions apply to individuals age 21 and over, and individuals with ME code 76 *(all ages)* and ME code 09 *(age 21 and over)*:

Full upper and lower dentures are covered.
•Dentures *must be* prior authorized (PA).
•Covered dentures include: D5110, D5120 *(complete)* D5130, D5140 *(immediate)*
•Refer to Section 13.33 of the dental manual for information regarding replacement dentures.

Dentures *are not covered* under the following circumstance:
* Dentures continue to be an *uncovered* service for ME code 76 and ME code 09.
* Full dentures *will not be* authorized within two years of a partial denture.
•Extractions and services to prepare the mouth for routine dentures are *not* covered.
•Rebases, relines, and repairs for dentures are *not* covered.

Partial dentures are *not* covered unless they are determined to be medically necessary as a result of trauma or medical condition.

•X-rays are required when submitting the PA request for partial dentures. The following partial denture procedure codes require a PA:
D5211, D5212, D5213, D5214

Custom-made Items

•Partial dentures that were ordered or fabricated prior to7/1/02 and placement was on or after 7/01/02 are covered under the custom-made item policy. Refer to Section 13.10 for further information on the custom-made policy.

•If the recipient will not be eligible for the partial denture after the service is first initiated *but* before the partial denture is actually ordered or fabricated, (July 1, 2002 or after) the recipient *must be immediately advised that completion of the work and delivery or placement of the item is not covered by Medicaid.* It is then the recipient's choice whether to request completion of the work on a private payment basis.

Services are covered to determine and treat trauma.

•All services related to trauma *must be* medically necessary.

•Claims related to trauma *must be* accompanied by a Certificate of Medical Necessity form explaining the nature of the trauma, and the basis for the services rendered.

When the claim is accompanied by a Certificate of Medical Necessity, the following services are covered to determine the extent of the trauma:

Evaluation and Management
99201 -99343, 99050, 99058
D0140, D0150, D0160, D0170
Diagnostic
D0210, D0220, D0230, D0240
D0250, D0260, D0270, D0272
D0274, D0277, D0290, D0310
D0330

Refer to the list of Medical and Surgical codes at the end of this bulletin that are covered, however, many have restrictions and limits.

DENTAL EXCEPTION SERVICES

Services may be covered to treat a medical condition without which the health of the individual would be adversely affected. The following benefits, limits, and restrictions apply to the dental exception:

•Services *must be* medically necessary and coverage will be determined on a case-by-case exception basis.

•Claims related to a medical condition *must be* accompanied by a Certificate of Medical Necessity form ***and*** a prescription or referral from a physician that documents the need for dental care to treat the medical needs of the patient.

DENTAL SUPPORT SERVICES

When medically necessary, dental services to support the treatment for the trauma or medical condition are covered on a ***case-by-case exception basis.***

Dental support services *cannot* be billed separately. Dental support services are listed under procedure code 41899 on the claim form.

For example, an extraction is not normally covered, however may be medically necessary in the treatment of an injury to the face.

In some cases, a root canal or filling may be needed in order to alleviate the potential for infection that could adversely affect the medical condition of the individual (pregnant woman, transplant recipient, chemotherapy patient etc.)

The following procedure codes are not covered but will be considered for coverage as a support service when the claim is accompanied by a Certificate of Medical Necessity form, ***and*** a physician's referral or prescription (when required). NOTE: Some services require a PA.

Tests and Laboratory Exams
D0999

Preventive
D1110
Fluoride Treatments

D1204
Restorative
D2110, D2120, D2130, D2131
D2140, D2150, D2160, D2161
D2330, D2331, D2332, D2335
D2380, D2381, D2382, D2385
D2386, D2387, D2388, D2799
D2910, D2920, D2930, D2931
D2932, D2940, D2950, D2951
D2952, D2953, D2954, D2955*(PA)*, D2957, D2999
Endodontics
D3110, D3120, D3220, D3221
D3230, D3240, D3310, D3320
D3330, D3331, D3332, D3333
D3346, D3347, D3348, D3351
D3352, D3353, D3410, D3421
D3425, D3426, D3430, D3450
D3910, D3999*(PA)*
Periodontics
D4210, D4211, D4220, D4240
D4245, D4260, D4320, D4321
D4355, D4381, D4910, D4999*(PA)*
Prosthodontics (PA required)
D5211*(PA)*, D5212*(PA)*, D5213*(PA)*, D5214*(PA)*
Removable Prosthetics
D5899*(PA)*
Fixed Partial Dentures
D6930, D6999*(PA)*
Oral and Maxillofacial Surgery
D7110, D7120, D7210, D7130
D7220, D7230, D7240, D7241
D7250, D7290, D7291*(PA)*
Alveoloplasty
D7310, D7320
Appliance Therapy
D8210*(PA)*, D8220*(PA)*
Adjunctive General Services
D9110*(PA)*, D9610, D9910, D9911 D9930, D9999

NON-COVERED ADULT DENTAL SERVICES

NOTE: Many dental services were previously only covered for children under age 21 and have never been covered for adults. Those codes are not listed here.

The following services are *no longer covered* for adults:
Clinical Oral Exams
D0120
Space Management Therapy
D1515
Preventive
D1550
Restorative
D2933
Adjustments to Dentures
D5410, D5411, D5421, D5422
Repairs to Complete Dentures
D5510, D5520
Repairs to Partial Dentures
D5610, D5620, D5630, D5640
D5650, D5660
Denture Rebase Procedures
D5710, D5711, D5720, D5721
Denture Reline Procedures
D5730, D5731, D5740, D5741,
D5750, D5751, D5760, D5761
Interim Prosthesis
D5820, D5821
Removable Prosthetics
D5850, D5851
Fixed Partial Dentures
D6980
Other Surgical Procedures
D7281
Adjunctive General Services
D9430

ADULT DENTAL BILLING INSTRUCTIONS

A Certificate of Medical Necessity form is required with all claims for adult dental services except for dentures.

Dentures
Dentures that have been prior authorized are billed using the authorized denture code.

Services for the treatment of trauma or a medical condition are covered under the following methodology:

▪Each claim for trauma *must* have a Certificate of Medical Necessity form attached.

▪Each claim for a medical condition *must* have a Certificate of Medical Necessity form ***and*** a physician's prescription or referral attached.

- •Office visits and x-rays *must be* billed using the appropriate CPT or ADA code.
- •Medical and surgical procedures *must be* billed using the appropriate CPT or ADA code. Refer to the list of Medical and Surgical codes at the end of this bulletin.
- •Injections *must be* billed using the appropriate injection code.
- •All non - surgical or medical dental procedures that are medically necessary support services for trauma or a medical condition *must be* billed on a single claim detail line using procedure code 41899.
- •The billed amount for procedure code 41899 *must be* the total of all related support services.

* Related services *must be* listed on the claim in field 59 using the date of service, procedure code(s), tooth number(s), surface code(s), and quantity, to identify the individual support services. Providers should show the usual and customary charge in the "fee" area for the support service procedure codes.

The dental support services *will not appear as paid items* on the remittance advice (RA). All support services that are deemed medically necessary will appear on the remittance advice as a lump sum payment under procedure code 41899.

PA REQUESTS

NOTE: A Certificate of Medical Necessity form must be submitted with the claims for medical and surgical procedures and dental support services, even if the service has been prior authorized.

PAs requested with the incorrect TOS will be returned to the provider and claims may deny.

PAs for Medical and Surgical Procedures

CDT-3 procedure code D4341 *(Periodontal scaling and root planing, per quadrant),* and CPT surgical procedures 21086, 21087, and 21088 listed in Section 19.16 of the manual require a PA.

When requesting a PA for the above listed surgical procedures, the correct Type of Service (TOS) on the PA request form is "2". ***Do not use a TOS "7" when requesting a PA for these dental surgical procedures.***

Approved medical and surgical procedures are listed on a detail line of the claim form.

PAs for Dental Support Services

Other dental procedures listed in this bulletin that require a PA, *must be* requested with a TOS 7 on the PA request form. The PA request form is submitted with the dental service code in field 18 of the PA request form. *Do not request a PA using procedure code 41899.*

The following codes require a PA (TOS 7):
D2955, D3999, D4999, D5211, D5212, D5213, D5214, D5899, D6999, D7291, D8210, D8220, and D9110.

If the PA request for a dental support service is approved, the approved procedure code is listed as a support service under 41899 on the claim form. The authorized dental support service will appear on the remittance advice as *not* covered, however the reimbursement will be included with 41899.

PAs for Dentures

A PA request for full dentures is submitted with TOS 7 and the appropriate denture code. An approved denture is listed on the claim form using the approved denture procedure code.

CERTIFICATE OF MEDICAL NECESSITY

Providers may reference Section 7 of the online provider manual for information regarding the Certificate of Medical Necessity form. A copy of the form is found in the provider manual.

Reference Section 3.7 of the online provider manual for information on ordering a supply of the Certificate of Medical Necessity forms.

INJECTIONS

The following injection codes are no longer valid under the dental program:

J2970; Z2016 - Z9536; J9000-J9280, and all injection codes with modifiers YA, YB, YC, YD, and YE.

Medically necessary injections administered in the course of treatment of the trauma or medical condition are covered. Refer to Section 19.15 of the manual for a list of HCPCS injection codes.

When billing for injection procedure codes, the provider *must* enter the number of units administered to the recipient in Field 59 (Qty.) on the dental claim form.

The following injection codes

have been added as a result of 2001/2002 HCPCS:

DESCRIPTION AMOUNT	MAXIMUM ALLOWED
J0692 *(Cefepime hydrochloride, 500 MG)*	$7.60
J1095 *(Dexamethasone acetate, /8 mg)*	$5.63
J2270 *(Morphine sulfate, up to 10 mg)*	$1.15
J2250 *(Midazolam HCl (Versed per mg)*	$2.70

PROCEDURE CODE APPENDIX

The Dental Procedure Code Appendix of the dental manual replaces Sections 19.2 through 19.14 of the dental manual. The Dental Procedure Code Appendix will be available soon at: www.dss.state.mo.us/dms

PERIODONTAL SCALING and ROOT PLANING

When medically necessary, procedure code D4341 *(Periodontal scaling and root planing, per quadrant)* requires a PA submitted with pretreatment x-rays (a full mouth survey taken within the last 12 months) and periodontal chart. The following guidelines are used to determine medical necessity for approval of the PA request:

•Verifiable signs of early or moderate chronic periodontia;

•Records must show two or more sites in the quadrant being treated with;

•probing depths of 5mm or greater; ***and***

•early to moderate bone loss, ***or***

•radiographic evidence of subgingival calculus.

Definition of Bone Loss

Early bone loss is cratering, or horizontal or vertical loss .

Moderate bone loss is notable bone loss with 50% of the root remaining in the bone.

Cases with greater than moderate bone loss will be evaluated on an individual basis as to the potential of maintaining the teeth. Hopeless cases will be denied.

If prior authorized, code D4341 is only billable as a medical surgical service when submitted with a Certificate of Medical Necessity form ***and*** a prescription or referral from a physician that documents the need for dental care to treat the medical needs of the patient.

MEDICAL and SURGICAL

The following medical and surgical services are billable on an individual detail claim line and *must not* be billed under 41899:

Periodontics
D4341*(PA/TOS2)*, D4355, D4920
Maxillofacial Prosthetics
D5913, D5914, D5919, D5922
D5926, D5927, D5932, D5934
D5935, D5936, D5952, D5953
D5954, D5955, D5958, D5959
D5960, D5988, D5999
Implant Services
D6010, D6020, D6040, D6050
D6090, D6095, D6100
Oral and Maxillofacial Surgery
D7260, D7270, D7285, D7286
D7340, D7350, D7410, D7420
D7430, D7431, D7440, D7441
D7450, D7451, D7460, D7461
D7465, D7471, D7480, D7490
D7510, D7520, D7530, D7540
D7550, D7560, D7610, D7620
D7630, D7640, D7650, D7660
D7670, D7680, D7710, D7720
D7730, D7740, D7750, D7760
D7770, D7780, D7810, D7820
D7830, D7840, D7850, D7860
D7865, D7870, D7871, D7872
D7873, D7874, D7875, D7876
D7877, D7880, D7910, D7911
D7912, D7920, D7940, D7941
D7943, D7944, D7945, D7946
D7947, D7948, D7949, D7950
D7955, D7960, D7970, D7971
D7980, D7981, D7982, D7983
D7990, D7991, D7995, D7996
D7997, D7999
Adjunctive General Services
D9212, D9220, D9221, D9230
D9241, D9242, D9248, D9310
D9420

Refer to the dental manual Section 19.16 for CPT medical and surgical procedure codes that *must* also be billed on an individual detail line.